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Actuarial Memorandum

Health Net Life Insurance Company
Individual Policy Filing

Qualifications

I, Gary L. Brace, am a member of the American Academy of Actuaries and meet its qualification standards for actuaries issuing statements of actuarial opinions in the United States. This filing is prepared on behalf of Health Net Life Insurance Company (the "Company") to comply with California Insurance Code section 10181.6 (b) (2). It may not be appropriate to use for other purposes.

I am affiliated with Milliman, Inc. ("Milliman") an independent actuarial consulting firm that is not affiliated with, nor a subsidiary, nor in any way owned or controlled by a health plan, health insurer or a trade association of health plans or insurers.

Scope

As a consulting actuary with Milliman, I have written this actuarial memorandum at the request of the Company to discuss the annual rate filing for its Individual policies, with form number P30601. The proposed rates included in this filing will be effective for new and existing members enrolling or renewing on or after October 1, 2011. The proposed rates represent an average increase of 11.9% over the currently filed rates. The increase in rates across benefit plans ranges from 0% to 18%.

This statement of opinion complies with the Actuarial Standards of Practice No. 8 and No. 41, promulgated by the Actuarial Standards Board.

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Reliance

I have relied upon information provided by Mr. Robert F. Kuecks, ASA, MAAA, Vice President and Actuary at the Company. While I reviewed the information for reasonableness, I did not audit the underlying data for correctness. Appendix A contains Statement Regarding Accuracy and Completeness of the Underlying Data Sources provided to me as part of my review, and forms a part of this opinion.

Testing Procedures

As part of my review, I followed the testing procedures outlined in Appendix B.

Opinion – Actuarially Sound in the Aggregate

In my opinion, the proposed premium rates are actuarially sound in the aggregate because the premium rates for business in California, including reinsurance recoveries, support expected health benefit costs, settlement costs, marketing and administrative expenses, and cost of required capital as provided to me by the Company.

An example of the rate calculations for Simple Value 30 is attached in Appendix C. A description accompanies each calculation. Since all of the products within this policy form were developed using similar methodology, only one example is shown.

Opinion – Reasonable Premium Rate Increases

In my opinion, the proposed premium rate increases are reasonable. I based my opinion of reasonable rate increase on the factors below. The assumptions, data used and other relevant information used in the rating filing development are included in Appendix C.

1. The expected loss ratio for all of the individual products, for the 12 month period between January 1, 2011 and December 31, 2011, after the proposed rate increase, is 90.9%. The loss ratio is determined as the ratio of projected incurred claims divided by projected revenue, consistent with the statutory reporting definition for premium revenue.

While the definitive loss ratio according to the PPACA MLR requirements can only be determined after the experience has emerged, I did calculate the projected federal loss ratio of 91.37%.

I used the following calculation:

Projected Federal Loss Ratio for 12 Month Period Beginning January 1, 2011 to December 31, 2011 for All of the Individual Products

(a) Statutory Loss Ratio	90.9%
(b) Expected Pre-Tax Profit	-11.0%
(c) Federal Tax Rate for Company	32.6%
(d) Expected Federal tax (b) x (c)	-3.6%
(e) Premium tax	2.35%
(f) Preliminary Federal Loss Ratio [(a) /((1 – (d) – (e))]	89.8%
(g) Adjustment for Credibility of 38,913 life years	1.38%
(h) Deductible Adjustment Factor	1.12
(i) Final Federal Loss Ratio [(f) + (g) x (h)]	91.4%

The calculation of the loss ratio is determined using the guidance supplied in the NAIC Model regulations.

2. The rate increase is supported by substantial evidence of anticipated claims costs trends.

   a. I reviewed the data and metrics contained in numerous spreadsheets provided by the Company. The summarized results of these spreadsheets, such as the historic and future loss ratio, and trend rate development are presented in the Company's actuarial opinion or the Rate Filing Form.
   b. The prior rate increase history, the corresponding projected loss ratios and subsequent actual loss ratios are presented in Table 6 of the Company's actuarial opinion. Historically, the rate increases have been inadequate to achieve target loss ratios.
   c. A 17.7% rate increase was implemented beginning October 2010. The impact of this rate increase is still emerging. However, given

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the historic loss ratios from CY 2010 shown in Table 5 of the Company's actuarial opinion, the Company is still projecting a loss for this policy form.

3. The choice of assumptions relating to unit health care cost increases, per capita utilization increases, and other assumptions, is reasonable.

   a. I reviewed the trend development and have summarized the trend information in the chart below.

Trend Component	Annual Increase
Average unit cost increase across all medical service categories	8.3%
Average secular utilization increase across all medical service categories	2.5%
Average durational increase	0.0%
Increase due to selection bias	0.0%
Risk Margin	2.0%
Average impact of deductible leveraging across benefit plans	1.0%
Additional factors	0.0%
Total (based on multiplicative basis	14.3%

   A discussion of the source and development of the trend factors is found in the Company's actuarial opinion on page 7.

4. The documentation included in this rate filing is adequate in order to determine the reasonableness of the proposed rate increase.

   a. Table 8 in the Company's actuarial opinion presents the results, on a summarized basis of the entire individual block, of the historical and future product loss ratio. This table is the summarized version of a more detailed spreadsheet that was developed by the Company.
   b. Tables 9 through 12 present the same information for the individual products by deductible level.

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c. The tables included in the Company's Rate Filing Form contain a number of tables presenting claims trend rates by component of trend, by major service category and by geographic area.

5. The proposed rates result in rates between insureds within similar risk categories that are permissible under applicable California law, and the premium differences correspond to differences in expected claims costs between allowable risk classes.

6. The proposed rate increases are justified by credible experience data and anticipated changes in unit health care costs. There are nearly 34,000 members in the individual block.

7. The company's after-tax rate of return, including all segments and regions in which the Company operates over the past three years, has been as follows:

   - 2008 4.7%
   - 2009 15.5%
   - 2010 6.7%

   - In addition, the Company anticipates a rate of return of 3.7% in 2011.

   The calculation of the rate of return is based on net income (after tax) divided by the average capital and surplus.

   I reviewed these metrics, but I did not rely upon the ROE, since it was not considered explicitly in the rate development process.

8. The executive compensation is part of the overall administrative expense assumed in the premium development. I received a listing of the top ten most highly compensated officers at the Company. I

reviewed the listing, but I did not rely upon the compensation levels since it was not considered explicitly in the rate development process.

9. The proposed average overall annual premium rate increase of 11.9% is greater than the Consumer Price Index for All Urban Consumers, U.S. City average of 2.9%, for the period April 2010 through April 2011.

   While the proposed rate increase is larger than the medical costs index, material differences between the two measures provide an explanation as to the reasonability of the rate increase. The medical component of the CPI measures price inflation at the retail level. That is, it measures the prices paid for a fixed market basket of medical goods and services. The medical CPI is a retrospective measure and does not account for expected future spending, which is the basis for premium rate setting.

   The following factors are included in the medical insurance claims trends that are not included in the CPI measure:

   - Increased per capita utilization of services
   - Cost for new technologies
   - Changes in provider practice patterns or the intensity of the service being provided
   - Changes in enrollment mix
   - New mandated benefits
   - Adverse selection
   - Deductible leveraging effect
   - Changes in provider mix and negotiated provider payment arrangements

   I reviewed the medical trends as part of the premium development. The medical trends are built from a “first principles” approach using the expected unit cost increase by hospital and medical group, and then weighted using the historic volume associated with each provider entity. Expected per capita utilization is also assumed to increase, and incorporated into the expected medical claims trend.

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I found the medical claims cost trends reasonable based upon my review.

10. As mentioned above in the Scope Section, the increase in the premium results in an 11.9% increase in the currently filed rates.

11. The capital and surplus level for the Company at December 31, 2010 is $414,490,199. The dividend history for the past three years is as follows:

2008 $0
2009 $35,000,000
2010 $0

I reviewed the dividend history, but I did not rely upon it since it was not considered explicitly in the rate development process.

12. The unisex age rating factors remain unchanged from the previous filing, so the premium rates for each age increase identically. The increase for each benefit plan is also identical. Consequently, the premium rate change does not result in any unreasonable increase for any particular cohort of policyholders.

13. The Company has regular management agreements and service contracts between itself and its affiliated companies, as well as reinsurance agreements. There have also been dividend and capital infusion transactions. This business is impacted by certain management and service contracts with affiliates as indicated in Schedule Y of the Company's annual statements. The amounts of these transactions over the past three years are shown in the following table.

Transactions with Affiliates* ($000 omitted)			
Transaction Type	2008	2009	2010
Dividends	0	(35,000)	0

Capital Contributions	130,000	0	0
Mgmt Agreements / Service Contracts	(199,572)	(183,536)	(188,429)
Reinsurance Income /(Disbursements)	(3,452)	(651)	(7,668)
Reinsurance Recoverable (Payable)	85,716	10,166	34,784

* Schedule Y of the Annual Statements

14. The cumulative lifetime loss ratio for this product on a net present value basis is 77.2%. The future loss ratio is 107.9%. The total lifetime and future loss ratio on a net present value basis is 85.6%.

Respectfully Submitted,

Gary L. Brace
Member of the American Academy of Actuaries
July 26, 2011

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Appendix A
Statement Regarding Accuracy and Completeness
Of the Underlying Data Sources

Items Relied upon During Testing by Milliman

- Numerous spreadsheets outlining the data collection and parsing process.
- Three spreadsheets, in particular, one calculating the necessary rate increase based on the claims experience, a second spreadsheet calculating the historic loss ratio and a third one calculating the future loss ratio.
- Spreadsheets presenting the development of the unit cost portion of the pricing trend rates, including utilization increase assumptions.
- Conversations with Health Net staff discussing the development of the renewal rating process

The sources identified above were relied upon by Milliman, Inc. in preparing this statement of actuarial opinion.

I, Robert F. Kuecks, Vice President of Actuarial Services, hereby affirm that the data sources identified above, and attached to this statement, were prepared under my direction, and to the best of my knowledge are accurate and complete unless otherwise noted below.

_____ _____

Date Signature

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Appendix B
Description of Testing Procedures

Under my direction, we reviewed the entire renewal rating process performed by Health Net Actuarial staff including:

1. Reviewed claims costs trend rates and development of anticipated unit health care cost and utilization increases
2. Reviewed the parsing of data into premium rating cells
3. Reviewed development of projected claims costs and comparison to revenue generated from application of current rates to current enrollment
4. Reviewed proposed rate increase based on comparison of projected loss ratio to target loss ratio
5. Reviewed Health Net recommended rate increases compared to arithmetically derived rate increases.
6. Documented and produced the step-by-step rating methodology and reviewed the correctness of each step.

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Appendix C

Description of Data, Assumptions, Rating factors and Methodology

Rating Example for PPO Product

The rating methodology follows this page

Assumptions Used as part of Base Rate Renewal Process

The assumptions used in the rating methodology are included in the Excel file submitted as part of this filing for the California Rate Filing Form. The assumptions are also presented in an attached listing following the rating methodology.

Health Net of California
PPO Rate Buildup Example
Appendix C - Total Individual PPO
CDI Request #7d

Rating Process	Member Months	Earned Revenue	Medical Claims	Rx	HCC Amount	MLR	Description
1. CY 2010 Experience period data	464,638	$88,003,364	$71,968,494	$4,497,556	$76,466,051	86.9%	Claims and enrollment pulled from mainframe. Parsed into products.
2. Current May 2011 membership	34,394						
3. Average medical claims trend across all service categories			14.30%	12.50%			Medical trend taking into account deductible leveraging and a 2% risk margin
4. Weighted average months of trend from actual month of incurred claims in experience period through center date of rating period			19.87	19.61			Center date of Experience is July 1, 2010. Center date of rating period is April 1, 2012.
5. Trended claims based on Cy2010 distribution by plan design (step1 * (100% + step3) ^ (step4 / 12 months))		$103,943,537	$89,797,926	$5,452,138	$95,250,064	91.6%	2010 dollars trended to the rating period. Revenue is calculated with the the current rates and 2010 membership.
6. Trended claims pmpm		$223.71	$193.26	$11.73			
7. Change in membership distribution factor		0.92	0.90	0.85			
8. Trended claims pmpm adjusted for change in membership distrubtion by plan design as of May 2011 (Step 6 * Step 7)		$205.87	$174.44	$9.97			
9. Trended claims weighted by May 2011 membership (Step 8 * Step 2)		$7,080,793	$5,999,762	$342,937	$6,342,699	89.6%	Dollars converted to May 2011 amounts
10. G&A based on current membership as of May 2011					$1,047,243		General and administrative expenses
11. Required premium revenue based on current membership					$8,518,287		Total expenses inclusive of admin, commissions, tax, and profit
12. Required rate increase					20.3%		Rate increase needed to cover claims, admin, commissions, tax, and profit
13. Requested 10/1/2011 rate increase					11.8%		Requested rate increase
14 Expected MLR for rating period based on requested rate increase					80.1%		Expected loss ratio
Estimated commission rate 15.					7.9%		Estimated average commissions including general agent override
16 Premium tax rate					2.35%		Premium tax of 2.35%
17 Formula based profit target					3.0%		Formula based profit target of 3.0%